REPORT OF OPHTHALMOLOGICAL CASES.*

By F. A. HAMLIN, M. D., San Francisco.

Convergent Squint.

Case 1. This case has been selected for presentation chiefly on account of the age of the child.

Convergent Strabismus is usually first observed in a child at about the age of 4-6 years, being the age when accommodation is first put to more active test, and by the mother is often referred to some acute infection just preceding, as the causative factor. Among the causes of squint may be mentioned: 1. Disturbance of relation between accommodation and convergence by errors of refraction. 2. Disparity in length, thickness, or tension of opposing muscles. 3. Size and shape of eyeball and orbit. 4. Influence of angle gamma. 5. Amblyopia of one eye.

Treatment of Convergent Concomitant Squint may be briefly outlined under three headings. 1. Spectacles. 2. Orthopic training, i. e., the child must see double or be trained to see double and then taught to fuse the double images (this necessitates much time, care and detail).

3. Operative methods. 1. Tenotomy of the Internal Rectus, or 2. Advancement of the External Rectus, or 3. Both.

I will here mention only the first.

Spectacle Treatment. This should include in children, atropin mydriasis with observation and measurement of eyes while the accommodation is paralyzed and pupils large. This will mean Retinoscopy with measure also of corneal astigmatism. Generally, we find hypermetropia, and often considerable astigmatism; therefore, if either of the other methods of treatment is adopted, we may still be obliged to prescribe spectacles.

Prognosis. "Glasses alone will many times suffice to cure," says De Schweinitz. Long and Barret, reporting 102 cases of convergent Strabismus which had worn glasses from six to twenty-four years, conclude that glasses cure 10% quickly and completely: 33% are cured if they continue to wear spectacles.

Age to prescribe Glasses:

Text books when mentioning any age usually say "give glasses to child 5-6 years old or over." De Schweinitz says "as soon as safe to wear." I think we all agree that if a child can be made to wear and look through the lenses, the effect will vary directly as the age of the patient. This little girl came to us four months ago when hardly 17 months' old. We found a convergent Strabismus of O.S. 20 degrees with some tending to alternation. Retinoscopy showed hypermetropia of 2.5D. with an astigmatism of +0.5D. axis vertical. We prescribed lenses of +2.0, asking the optician to take especial care in adoption of frames.

The child has worn the spectacles constantly, neither frames nor lenses have been broken and now you can see that the eyes are perfectly straight.

Case 2. This case is presented for three reasons, viz:

1. Its treatment. 2. Because it represents a type which goes to make up a large percentage of our clinical material. 3. Because it is of interest to other departments as these cases have often been to the Children's Clinic, Skin Clinic, and Throat Clinic.

Shall we hastily review some of the chief points concerning phlyctenular ophthalmia or scrofula ophthalmia or phlyctenular conjunctivitis and keratitis.

This is characterized by a circumscribed inflammation accompanied by formation of one or more small reddened projections or "phlyctenulae." These latter are accumulations of lymphoid cells which soften at their apices and form small ulcers.

Age: Children and youths are especially susceptible though it may occur in adults. A single large phlyctenule in adult gives local appearance of episcleritis.

Subjective Symptoms: The two chief subjective symptoms are photophobia and blepharospasm.

Objective Symptoms: We see one or more small nodules, size of millet seed, reddish and on conjunctiva or cornea or at limbus. This phlyctenulae is surrounded by conjunctival hyperemia but non-affected parts of ocular conjunctiva are fairly normal. When on the cornea the ulcer resulting may be superficial and heal and leave no changes in the cornea or may spread into corneal substance and leave permanent opacity or may even perforate. There is usually considerable lachrimation but no secretion. If there is any discharge it is mucous or mucopurulent.

Course: The phlyctenulae appear in crops,—each crop lasting from five to fifteen days. Relapses are common.

Complications: This trouble is often accompanied by blepharitis; excoriations and exzema of the lids and face, and nares and swelling of the cervical lymph glands. Rhinitis is always present.

Etiology: It is found especially among those who suffer from strumous, scrofulous or tubercular diathesis. The lower classes suffer most, as here, dirt, poor food, bad hygiene, etc., are contributing factors. At times it is seen in children of apparently good health and of the better classes. Micro organisms have been described but inoculations were negative. One of these resembled "coccus flavus desidens." Astigmatism some authors consider an important factor.

Treatment: Proper diet, plenty of air and sunshine. Hydrotherapy, cold bath and plunge for the face.

Tonics: e. g., iron, quinin and cod liver oil.

Locally: Yellow oxide or calomel. Cautery if necessary to control the ulcers.

Two points I would emphasize:

1. Allow no bandage or cover of any kind.
2. Treat the nasal condition, with yellow oxide.

This little Chinese girl came to clinic with a severe eczema of the right side of the face and lip and right nares. The lip was very much swollen and the right eye showed several typical phlyctenulae in various stages. The nasal and lip condition was especially noticeable, being so distinctly unilateral and so severe. During the treatment the other eye and left nares showed only very slight disturbance.

Treatment above, as outlined, was followed with immediate improvement and you see the child now nearly well. The eye condition cleared and the nasal and face trouble scarcely noticeable. While under our care tests were made for luetic or tubercular conditions, but both the Wasserman and Moro reactions were negative. The child has gained in weight and I am sure that those who may have seen her in other clinics will note a very remarkable change,—in fact she is a very different child in appearance.

Case 3. The pelvis of this kidney as you see is literally filled with a calculus. The patient, age 40, laborer, came to us complaining of failing vision. Gave no history of kidney trouble except had "passed gravel a few times." The fundus showed the classical picture of albuminuric retinitis with numerous small hemorrhages. Patient felt very well with the exception of headaches but asked only to have the vision improved and he would be satisfied. The patient was persuaded, with great difficulty, to enter the hospital. The post mortem was made ten days later. I present the specimen to show how severe and long standing a kidney lesion may be before noticed.

* Read before Cooper College Science Club, February, 1910.